Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004444	A. BUILDING: _____ B. WING _____	C 04/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER PLACE	2216 N RILEY HWY SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00146577. Complaint number IN00146577 Substantiated. No deficiencies related to the allegations are cited. Survey Dates: April 24 2014 Facility number: 004444 Provider number: 004444 AIM number: NA Survey team: Chuck Stevenson RN Census bed type: Residential: 27 Total: 27 Census payor type: Other: 27 Total: 27 Sample: 3 Walker Place was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00146577. Quality Review 04/25/14 by Lisa McColly	R 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE